DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
2050 WORTH ROAD, SUITE 10
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO
ATTENTION OF

MCHO-CL-P (40)

11 Jul 00

MEMORANDUM FOR Commanders, MEDCOM RMCs/MEDCENs/MEDDACs

SUBJECT: Telemedicine Specialty Consultations

1. References:

a. Assistant Secretary of Defense (Health Affairs)(ASD(HA)), Policy 98-107, subject: Policy for Specialty Care Consultants, 7 January 1998.

b. Medical Expense and Performance Reporting System (MEPRS) Manual, DOD 6010.13-M, October 1995.

c. Code of Federal Regulations (CFR), General Services Administration, Interagency Committee on Medical Records, Guideline on Documentation of Telemedicine and Guideline on Videotaped Documentation of Surgical Procedures and Other Episodes of Care, Volume 64, Number 237, 9 December 1996.

d. CFR, General Services Administration, Interagency Committee on Medical Records, Guidelines for Videotaped Documentation of Episodes of Medical Care, Volume 64, Number 233, 6 December 1999.

2. Based on current ASD(HA) policy (reference paragraph 1a. above), military treatment facilities are to provide clearly legible specialty care visit report from the specialist to the primary care manager within seventy-two (72) hours of the specialty encounter. This same standard applies to specialty care telemedicine consultants.

3. With respect to workload accounting under MEPRS (reference paragraph 1b. above), if a patient is present in a provider's office and another provider is contacted through telemedicine, both providers receive a clinic visit count. This is considered a valid medical consultation and, as such, it requires proper medical documentation by the consulted provider, ensuring that the criteria of a visit are met. Workloads will not be counted if the patient is not present during the consult.

4. The CFR (reference 1c. above) states that when an episode of health care is to be documented by videotape (i.e., surgical procedures, medical evaluation, or telemedicine consultation), the patient must provide written consent before the taping (unless the consultation is for the documentation of abuse or neglect).

a. The episode of care should be documented in accordance with current regulations/procedures. Videotapes are not part of the medical record. The videotape should be erased after documentation is completed in the medical record. In the documentation of the medical record, the provider should indicate whether or not the image was erased or where the videotape will be maintained if the videotape is required for a specified interval for a specific reason (i.e., documentation of a procedure for board certification or documentation of abuse or neglect).

b. Exceptions are allowed for those cases with educational value. The rule of thumb should be that if a case does not hold educational value and there is no legitimate medical reason to videotape, then videotaping is probably not justified.

5. Any questions regarding this matter should be addressed to the Patient Administration Division, Office of the Assistant Chief of Staff for Health Policy and Services, DSN 471-6113; Commercial (210) 221-6113.

FOR THE COMMANDER:

WILLIAM T. BESTER
Brigadier General, AN
Deputy Chief of Staff for
Operations, Health Policy
and Services